VERMONT HEALTH ACCESS PROGRAM
MULTIPLE ADJUSTMENT REQUEST FORM

1. PROVIDER NAME, ADDRESS & NUMBER	2. SPECIFY CHANGE & REASON FOR ADJ.
NAME: ADDRESS: Provider #:__ _____ and/or NPI # ___ _____ Taxonomy Code _____ _____	
SIGNATURE **(required)**	DATE

IMPORTANT: THIS ADJUSTMENT WILL NOT BE PROCESSED UNLESS ALL FIELDS ARE COMPLETED AND INFORMATION IN BOXES 1-10 MATCH INFO ON CLAIM'S ICN.

EDS	(3) CLAIM INTERNAL CONTROL NUMBER	DTL	(4) BENEFICIARY NAME	(5) BENEFICIARY MEDICAID #	(6) DOS FROM	TO	(7) Billed AMT	(8) PAID AMT	(9) PAID DATE	(10) R/A DATE

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This form can be downloaded to your computer for your convenience. It is a 'locked' form; allowing you to fill in the required fields without altering the basic form. Please save all completed forms for your records. After filling in the required information, save your document, print the form and mail it to EDS, PO Box 888, Williston, VT 05495.

INSTRUCTIONS FOR FORM COMPLETION

Adjustment requests may be submitted to EDS when a claim is paid incorrectly. The provider, EDS, or OVHA can initiate these requests. All adjustments must be submitted on an Adjustment Request Form and all information must be provided. Telephone requests are not accepted.

A new claim form with the correct information is required when changing the provider number, beneficiary number. Any request, which does not have the proper attachments, will be returned.

Denied claims cannot be submitted as adjustment requests. A claim that has been denied should be corrected and resubmitted with all attachments as a new claim.

1. PROVIDER NAME, PROVIDER NUMBER, and/or NPI NUMBER, TAXONOMY CODE:
Enter the name of the provider to whom the claim was paid. Also enter the Medicaid provider number, NPI number, and Taxonomy Code to whom the claim was paid.

2. REASON FOR ADJUSTMENT:
PLEASE SPECIFY WHAT INFORMATION NEEDS TO CHANGE AND THE REASON FOR REQUEST.
If the request is to change information on the claim, please state " change____ from____ to____". Ex. " change procedure code from XXXX to YYYY ". If you want to recoup the paid amount, please state, " recoup claim " or "recoup detail(s) _____". Please be specific. When using the multiple adjustment request form, the reason for adjustment must be the same for all claims listed.

EDS USE ONLY:
Leave blank.

3. CLAIM INTERNAL CONTROL NUMBER:

The 15-digit internal control number (ICN) is found on the remittance advice directly following the beneficiary's identification number.

4. DTL
Please include the detail numbers requiring adjustment. If all details for the ICN require adjustment simply indicate "ALL".

5. BENEFICIARY NAME
Enter the name of the beneficiary for which the paid claim is being adjusted.

6. BENEFICIARY NUMBER
Enter the Medicaid Identification number of the beneficiary for which the paid claim is being adjusted.

7. FROM DATE OF SERVICE
Enter the from date of service for which the paid claim is being adjusted.

8. TO DATE OF SERVICE
Enter the to date of service for which the paid claim is being adjusted.

9. PAID AMOUNT
Enter the date of service for which the paid claim is being adjusted.

10. PAID DATE
Enter the paid date for which the paid claim is being adjusted.

SIGNATURE AND DATE
The adjustment request will be returned to the provider if a signature is not present.